Background

• History of CHEST

• CHEST Vision, Goals, and Strategies
History of CHEST

“Legacy of promoting patient-focused care through leadership, education, communication, and clinical practice”
Education

1935
ACCP is founded as the Federation of American Societies to educate the general practitioner and public about tuberculosis prevention and treatment.

1935
The first annual meeting is held August 9-10 in Albuquerque, NM. There are 38 registrants.

1945
Postgraduate courses are offered throughout the year to help educate physicians returning from service in WWII.

1952
The Committee on Mission Pictures is organized to relieve and promote awareness of diseases for education purposes.

1954
The first ACCP

1984
Simulation exercises are offered for the first time at CHEST 2005.

2000
The CHEST Foundation produces several tobacco prevention products targeting women, children, and minorities.

2005
Simulation exercises are offered for the first time at CHEST 2005.

2006
The first ACCP critical care board review course is offered.

2008
The ACCP Simulation Center opens in Northbrook, IL.

2009
A Physician’s Perspective is launched.

2009
ACCP Learning Categories are introduced to organize all education activities based on instruction method and learning maintenance of licensure designations are introduced.
CHEST Education

Annual Meeting

300+ GENERAL SESSIONS

POSTGRADUATE COURSES

10

INTERDISCIPLINARY SESSIONS

9

INTERACTIVE GAMES

11

UNIQUE SIMULATION SESSIONS

26
Past 10 Years

- **2011** - podcast series, first journal to launch a universal app for iPhone/iPad
- **2012** - began using image manipulation detection and plagiarism software
- **2013** - Ultrasound Corner first case-based series to intentionally leverage video in *CHEST*
- **2014** - rebranding of American College of Chest Physicians from "ACCP" to "CHEST" in recognition that the brand of the journal, was the *lead* brand; journal redesign employing the new blue identity scheme with the blue (for breath) as the focal color vs red
- **2016** - proactive decision to move away from self-publishing, identified Elsevier as publishing partner for an initial 7 year agreement
- **2018** - launched visual abstracts for use in social media and to convey the findings of key research in a new and easily consumable way
CHEST Top Articles


CHEST Top Articles


CHEST Top Articles


CHEST Top Articles


CHEST Top Articles


CHEST Top Articles


**CHEST Top Articles**


**CHEST** Top Articles


CHEST Top Articles

• Mountain CF. An international staging system for lung cancer. Chest 1986;89:225S-233S.


CHEST Top Articles


• Heart Transplants: Three Views.

  • “know the best that is taught in this branch of science the world over”
  • “two aspects in which we may view the teacher – as a worker and instructor in science and as a practitioner and professor of the art.”
CHEST Top Articles


• Heart Transplants: Three Views.

  • “know the best that is taught in this branch of science the world over”
  • “two aspects in which we may view the teacher – as a worker and instructor in science and as a practitioner and professor of the art.”
CHEST Top Articles


• Heart Transplants: Three Views.

  • “know the best that is taught in this branch of science the world over”
  • “two aspects in which we may view the teacher – as a worker and instructor in science and as a practitioner and professor of the art.”
**CHEST EIC Comments**

- “Adapted to the needs of clinical chest physicians and health-care professionals.”
- “Never waivered from its true mission to educate physicians about aspects of patient care. *CHEST* has always served the practicing clinician.”
- “Focused clinical orientation with its multidisciplinary coverage of topics. Improving patient care through education. What do our readers need and want to read now and in the future.”
- “Crucial that *CHEST* be relevant to ACCP members’ clinical experience.”
- “Publish content that will be meaningful and essential to a more diverse group of readers and subject matter that is easier and faster to read and access.”
• Adapt to the needs of pulmonary, critical care, and sleep medicine clinicians.

• Improve patient care by educating clinicians with content relevant to their clinical experience.
CHEST Vision, Goals, and Strategies
SERVING 19,000+ MEMBERS WORLDWIDE

OFFERING LIVE AND ONLINE EDUCATION

HOST OF WORLD’S LARGEST CLINICAL CHEST MEDICINE EVENT

350,000+ READERS USE CHEST, ALSO A PREMIER RESOURCE FOR CLINICAL PRACTICE GUIDELINES
Vision
• CHEST will be the global leader in prevention, diagnosis, and treatment of chest diseases.

Mission
• CHEST champions advanced clinical practice, education, communication, and research in chest medicine.

Values
• Collegiality, collaboration, innovation, data-driven, transparency, diversity, excellence, integrity, results-oriented
CHEST Strategic Plan - Goals

1. CHEST provides innovative education customized to individual learner needs, designed to improve knowledge, competence, performance and patient outcomes.

2. CHEST is the premier resource for clinically relevant scientific research, guidelines, and implementation strategies and tools.
   - Increase access and engagement with CHEST guidelines through article downloads, social media, and citations.
   - Rank in the top five pulmonary and critical care journals as measured by CHEST Kantar readership scores, Impact Factor, and Eigenfactor.
CHEST Strategic Plan - Goals

3. CHEST will **increase the global impact** of its education.
   - Increase access of journal content from outside the US.

4. CHEST **optimizes its assets** to achieve its mission and vision.
   - Develop and implement an integrated and coordinated publishing strategy and publications-related product roadmap.

5. CHEST has a **strong and diverse financial base**.
<table>
<thead>
<tr>
<th>Section</th>
<th>Very interested</th>
<th>Interested</th>
<th>Neither interested nor not interested</th>
<th>Not interested</th>
<th>Not at all interested</th>
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<td>46%</td>
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<tr>
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<td>41%</td>
<td>13%</td>
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<td>47%</td>
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<td>55%</td>
<td>12%</td>
<td></td>
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<tr>
<td>Chest Imaging and Pathology for Clinicians</td>
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<td>47%</td>
<td>17%</td>
<td>5%</td>
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<td>Point/Counterpoint</td>
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<td>42%</td>
<td>31%</td>
<td>7%</td>
<td></td>
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<td>Contemporary Reviews: Sleep</td>
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<td>31%</td>
<td>25%</td>
<td>17%</td>
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<td>Ultrasound Corner</td>
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<td>Pectoriloquy</td>
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<td>28%</td>
<td>47%</td>
<td>16%</td>
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NOTE: For visualization purposes, values below 5% are not displayed in the chart.

Sample: All respondents (n=465)
Q. Please rate your interest in the information found in each of the following sections of CHEST.
Vision and Goals

CHEST will be the most important source of clinically relevant research and patient management guidance for pulmonary, critical care, and sleep medicine clinicians worldwide.

1. Foster the submission of high quality clinically relevant research.
2. Enhance the clinical utility of evidence driven reviews.
3. Increase access to, and the desire to view, journal content.
High Quality Clinically Relevant Research

• **Engage** with those performing research *prior to submission* decisions.
  - Develop a list of sponsored clinically relevant research in our fields.
  - Have a presence at all relevant society meetings.
  - Build relationships with major medical journals.

• **Minimize the burden** of article submission.
  - Establish minimal requirement for data entry at time of submission.
  - Provide clear and interactive descriptors of how each article type will be judged, and tools to assist with manuscript preparation (e.g. algorithm templates).
High Quality Clinically Relevant Research

- **Timely review** and the provision of high quality feedback.
  - Rapid review commitment for initial decisions.
  - Decrease the time it takes to provide high-quality reviews.
  - Develop tools to assist reviewers.
  - Identify articles whose review can be expedited by editorial leadership.

- **Promote** the author’s work.
  - Multi-media.
  - Provide opportunities for presentation of the top content at our annual meeting.
Clinically Useful Evidence Driven Reviews

Evidence Driven Reviews

• Highest rated article type.

• >25% of our top referenced articles.

• Opportunity to impact clinical practice by promoting the implementation of clinical advances and guideline recommendations.
  • CHEST Reviews
  • CHEST “How I do it”
  • Build relationships with other societies.
Antithrombotic Therapy for Atrial Fibrillation
CHEST Guideline and Expert Panel Report

Gregory Y. H. Lip, MD; Anindita Banerjee, MD, DPhil; Giuseppe Bonatti, MD, PhD; Chunhui Chang, MD, PhD; Ramzi Fargi, MD, FCCP; Ben Friedman, MD, PhD; Deirdre A. Lane, PhD; Christian T. Ruff, MD, MPH; Mihoko Takaoka, MD; David Waring, MD, PhD; Shreela Tredwell, MSc, and Lisa Savins, MD, FCCP

BACKGROUND: The risk of stroke is heterogeneous across different groups of patients with atrial fibrillation (AF), being dependent on the presence of various stroke risk factors. We provide recommendations for antithrombotic treatment based on net clinical benefit for patients with AF at varying levels of stroke risk and in a number of common clinical scenarios.

METHODS: Systematic literature reviews were conducted to identify relevant articles published from the last formal search performed for the Antithrombotic and Thrombolytic Therapy: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines (6th Edition). The overall quality of the evidence was assessed using the GRADE (Grading of Recommendations, Assessment, Development, and Evaluation) approach. Gradual recommendations and upgraded consensus-based statements were drafted, voted on, and revised until consensus was reached.

RESULTS: For patients with AF without validated vascular disease, including those with paroxysmal AF, who are at low risk of stroke (e.g., CHADS2-VASc, <2), (congestive heart failure, hypertension, age ≥ 75 [disability], diabetes, stroke [doubled]; vascular disease, age 65-74 and not age ≥ 75 [disability]), dalteparin, enoxaparin, or fondaparinux may be used. For patients with AF and low to moderate risk of stroke (e.g., CHADS2-VASc, <3), (congestive heart failure, hypertension, age ≥ 75 [disability], diabetes, stroke [doubled]; vascular disease, age 65-74 and not age ≥ 75 [disability]), rivaroxaban, apixaban, or dabigatran may be used. For patients with AF and high risk of stroke (e.g., CHADS2-VASc, ≥3), (congestive heart failure, hypertension, age ≥ 75 [disability], diabetes, stroke [doubled]; vascular disease, age 65-74 and not age ≥ 75 [disability]), warfarin may be used. For patients with AF and very high risk of stroke (e.g., CHADS2-VASc, ≥4), (congestive heart failure, hypertension, age ≥ 75 [disability], diabetes, stroke [doubled]; vascular disease, age 65-74 and not age ≥ 75 [disability]), warfarin should be used.

FROM THE GUIDELINES

New cancer diagnoses

Prostate: 14%
Lung cancer: 86%
All other forms of cancer: 100%

Men vs Women

Lung cancer is the #1 cause of cancer deaths in women, and the number of women diagnosed with lung cancer is not decreasing.

Screening Recommendations

CT screening should be offered to:

- Smokers & former smokers, age 55-74, with more than 30 pack-years of smoking
- Annual low-dose CT screening should be offered in a setting that delivers the comprehensive care provided to National Lung Screening Trial participants.

CT screening not recommended for:

- With fewer than 30 pack-years of smoking
- Younger than 55 or older than 74
- With severe comorbidities that would preclude potentially curative treatment or limit life expectancy

Advances in Treatment

Published as a supplement to the May 2013 issue of the journal CHEST.
Access and Desire to View Content

Multi-media and Digital Content Development

- Audio/video discussions with the authors
- Descriptive video summaries of original articles
- Slide sets that display key results of original articles for download
- Seamless digital access with content organized and displayed as in the print version
Effectiveness of Reprocessing for Flexible Bronchoscopes and Endobronchial Ultrasound Bronchoscopes

<table>
<thead>
<tr>
<th>CLINICAL QUESTION</th>
<th>STUDY DESIGN</th>
<th>RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>To evaluate the effectiveness of real-world bronchoscope cleaning following use</td>
<td>Multisite, prospective study</td>
<td>Reprocessing practices were substandard</td>
</tr>
<tr>
<td></td>
<td>Assessments included</td>
<td>In fully-reprocessed bronchoscopes,</td>
</tr>
<tr>
<td></td>
<td>• visual inspection</td>
<td>100% had visual defects</td>
</tr>
<tr>
<td></td>
<td>• microbial cultures</td>
<td>100% had residual protein</td>
</tr>
<tr>
<td></td>
<td>• biochemical tests</td>
<td>58% had microbial growth</td>
</tr>
<tr>
<td></td>
<td>• observation of reprocessing practices and storage cabinet cleanliness</td>
<td>3 centers &amp; 24 bronchoscopes were assessed</td>
</tr>
</tbody>
</table>

Despite high level disinfection, residual contamination of bronchoscopes was frequent.

Ofstead CL et al. *CHEST* 2018;154(5):1024-1034
For perspective, please read the accompanying editorial by Mehta AC et al. *CHEST* 2018;154(5):1001-1002
CHEST Editorial Board

Deputy Editors
- Outreach
- Multi-Media
- Contributor Experience

EIC

Advisory Council
- Editorial Experience
- Leadership Experience
- Prior CHEST leadership

Publisher
- Director Guidelines and Publishing
- Journal Operations Manager
- Journal Operations Coordinator
- Editorial Coordinators
- Assistant Editor
- Statistical Editor
- Elsevier

Associate Editors
- Subspecialty expertise
- Editorial board organized under AEs
Subspecialty Team Tasks

- Manage the **article review process** for original article submissions within their subspecialty.
- **Recruit review articles** within their subspecialty.
- Contribute to **journal strategy**.
- Assist with review of high priority articles.
- Assist with the translation of content into multi-media formats.
## Subspecialty Teams

<table>
<thead>
<tr>
<th>Category</th>
<th>Topics</th>
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<tbody>
<tr>
<td>Asthma</td>
<td>Allergy and Airway, Occupational and Environmental Lung Diseases, Obstructive Lung Disease</td>
</tr>
<tr>
<td>Critical Care</td>
<td>Critical Care, Disaster Medicine, Palliative and End of Life Ethics, Respiratory Care</td>
</tr>
<tr>
<td>Chest Infections</td>
<td>Chest Infections, Pediatrics</td>
</tr>
<tr>
<td>COPD</td>
<td>Obstructive Lung Disease, Pulmonary Rehab, Respiratory Care</td>
</tr>
<tr>
<td>Diffuse Lung Disease</td>
<td>Diffuse Lung Disease, Occupational and Environmental Lung Disease, Pulmonary Manifestations of Systemic Disease, Transplant</td>
</tr>
<tr>
<td>Education and Clinical Practice</td>
<td>Education Teaching and Quality Improvement, Cultural Diversity, Imaging, Palliative and End of Life Ethics, Pediatrics, Signs and symptoms, Practice Management and Administration</td>
</tr>
<tr>
<td>Lung Cancer</td>
<td>Lung Cancer, Pleura, Procedures, Tobacco, Mediastinum</td>
</tr>
<tr>
<td>Pulmonary and CV</td>
<td>Pulmonary Hypertension, VTE, Cardiovascular, Antithrombotic</td>
</tr>
<tr>
<td>Sleep</td>
<td>Sleep Disorders</td>
</tr>
<tr>
<td>More than 2</td>
<td>Biotechnology, Genetic and Development Disorders, Imaging, Pathology, Physiology</td>
</tr>
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</table>
## Subspecialty Teams

<table>
<thead>
<tr>
<th>Category</th>
<th>Curriculum</th>
<th>Submissions</th>
<th>Publications</th>
<th>Journal Goal</th>
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<tr>
<td>Asthma</td>
<td>4</td>
<td>10.8</td>
<td>5.8</td>
<td>12</td>
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<tr>
<td>Critical Care</td>
<td>29</td>
<td>12.4</td>
<td>15.5</td>
<td>14</td>
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<tr>
<td>Chest Infections</td>
<td>6</td>
<td>18.2</td>
<td>10.8</td>
<td>10</td>
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<tr>
<td>COPD</td>
<td>10</td>
<td>11.8</td>
<td>18.5</td>
<td>12</td>
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<tr>
<td>Diffuse Lung Disease</td>
<td>8</td>
<td>1.6</td>
<td>10.0</td>
<td>12</td>
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<td>Education and CP</td>
<td>8</td>
<td>7.2</td>
<td>4.6</td>
<td>8</td>
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<tr>
<td>Lung Cancer</td>
<td>14</td>
<td>8.4</td>
<td>12.4</td>
<td>12</td>
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<tr>
<td>Pulmonary and CV</td>
<td>6</td>
<td>13.3</td>
<td>14.0</td>
<td>12</td>
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<tr>
<td>Sleep</td>
<td>13</td>
<td>6.9</td>
<td>8.1</td>
<td>8</td>
</tr>
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Editorial Board Composition

It is recommended that an 8 to 12-member subspecialty Editorial Board be selected by the Associate Editor to serve on their team. The members should include:

- Individuals with a combined expertise that will cover all of the content areas assigned to the Associate Editor’s subspecialty team
- A senior key opinion leader well-published and well-regarded in the field
- An individual(s) to champion topic selection and author recruitment for review and invited article sections
- An individual(s) to work with the multi-media team to identify content for delivery in non-traditional formats and assist with the review of these products
- Diversity of gender and geographic location, including international member(s).
- Consider inclusion of a non-physician provider.
Journal Submissions

- First Submissions
- Revised Submissions

Year | First Submissions | Revised Submissions
--- | --- | ---
2004 | 2707 | 0
2005 | 3149 | 1110
2006 | 2809 | 951
2007 | 2927 | 1030
2008 | 2881 | 863
2009 | 2971 | 872
2010 | 3235 | 925
2011 | 3277 | 955
2012 | 3043 | 905
2013 | 3035 | 834
2014 | 3257 | 898
2015 | 3047 | 709
2016 | 3133 | 665
2017 | 3056 | 654
2018* | 3072 | 708

**Pie Chart:**
- 35% US
- 65% Rest of World
Acceptance Rates (%)
Annual Original Research Articles Published

- 2012: 270
- 2013: 311
- 2014: 235
- 2015: 239
- 2016: 195
- 2017: 165
- 2018: 163
Impact Factor Trends
Summary

CHEST will be the most important source of clinically relevant research and patient management guidance for chest medicine physicians worldwide.

1. Foster the submission of high quality clinically relevant research.
2. Enhance the clinical utility of evidence driven reviews.
3. Increase access to, and the desire to view, journal content.